Electronically Delivered

December 31, 2025

Licensee
Heart to Home Incorporated
659 Mulberry Lane
Mendota Heights, MN 55118

RE: Project Number(s) SL25756016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25756	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INC	659 MULBERRY LANE MENDOTA HEIGHTS, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25756016-0 On December 15, 2025, through December 17, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag."The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 650		

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0 650	Continued From page 2 The findings include: ULP-E had a hire date of February 15, 2025, and provided direct care services to the licensee's residents. ULP-E's record lacked evidence of competency in the required areas of infection control, personal cares, transfers, exercise, ambulation, range of motion & positioning, vital signs, treatments and medication administration. On December 16, 2025, at 1:52 p.m., registered nurse (RN)-C stated ULP-E completed all the required competencies; however, the documentation of the competencies were not in ULP-E's employee record. The licensee's Employee Record policy dated February 1, 2025, indicated employee records for each person will include verification of completed orientation, annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 3 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 15, 2025, at 1:46 p.m. with licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, registered nurse (RN)-C, and director of operations (DO)-D, the surveyor made a request to review the licensee's TB risk assessment. The	0 660		

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0 660	Continued From page 4 TB risk assessment dated January 14, 2025, indicated the licensee was a 'low' risk. ULP-F's employee record showed ULP-F had a start date December 29, 2021, to provide direct care services. On December 16, 2025, at 9:57 a.m., the surveyor observed ULP-F administer R3's morning medications. ULP-F's employee record did not contain documentation of a completed health history and symptom screening. On December 16, 2025, at 1:52 p.m., RN-C stated ULP-F's employee record lacked the required TB history and symptom screening. ULP-F stated it may have been misplaced or missed. The licensee's TB Screening policy dated August 1, 2022, indicated staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. New staff will be screened for active signs of TB using the Baseline TB Screening tool for HCWs. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease).	0 660		

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0 660	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) completed all training and competency evaluations prior to providing delegated nursing tasks to one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01420		

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01420	Continued From page 6 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 began receiving services from the licensee on October 7, 2024, with diagnoses including encephalopathy, dysphagia, left hemiplegia/weakness, and post stroke. R2's Service Plan dated November 13, 2025, included the service of Dressing - Special 2 x daily with note: "assist the resident in managing special device needs: put the light therapy helmet on the head. Turn it on the select "GLOW" setting for 10 minutes before breakfast and after nap. Do this in her room in case she takes it off and falls on the floor. Notify nurse if there is a skin breakdown or you have concerns." In addition, the service of Grooming/Oral Cares - AM daily with note: "apply toothpaste to the auto toothbrush and hand it to the resident to place in their mouth. Turn on once positioned. When the brush shuts off, restart once. Place on the charger when finished." On December 16, 2025, at 9:05 a.m., the surveyor observed ULP-E assist R2 with application of Neuronic helmet (therapeutic infrared lamps that emit energy in the near-infrared spectrum, designed for use on the head to promote energy and relaxation) and removal after 10 minutes. Next, ULP-E applied gloves, applied coral nano silver foam to the auto toothbrush tray, placed into R2's mouth and repeated once. ULP-E	01420		

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01420	Continued From page 7 ULP-E had a hire date of February 15, 2025, to provide direct care services to the licensee's residents. ULP-E's employee's records lacked evidence of training and/or demonstrated competency for the Neuronic helmet and auto toothbrush. On December 16, 2025, at 1:00 p.m., registered nurse (RN)-C stated the provider provided instruction to staff on the Neuronic helmet and the auto toothbrush; however, they did not provide training or competency for the unlicensed personnel. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated A registered nurse or licensed health professional at [licensee name] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The facility will establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. The policy further indicated when the registered nurse or licensed health professional at [licensee name] delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to	01420		

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01420	Continued From page 8 competently follow the procedures and perform the tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620		

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01620	Continued From page 9 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a change of condition assessment for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 10 During the entrance conference on December 15, 2025, at 1:46 p.m., clinical nurse supervisor (CNS)-B stated comprehensive assessments were completed upon admission, within 14 days, every 90 days, and with changes in condition. R2 began receiving services from the licensee on October 7, 2024, with diagnoses including encephalopathy, dysphagia, left hemiplegia/weakness, and post stroke. R2's Service plan dated November 13, 2025, indicated R2's services included assistance with ambulation/exercise, bathing, behavior management, care for personal possession assist, dressing AM, dressing PM, dressing - special, grooming/oral cares, housekeeping, laundry, linen change, meal assistance, medication administration, mobility, position/re-position, reminders, and toileting. R2's Progress Notes included: -November 13, 2025, at 9:42 a.m., CNS-B documented a type of note named: service agreement/change in addendum/consent services. The note included discussion with R2 and POA (power of attorney) regarding consent for addendum to contract service agreement. CNS-B contacted R2's niece (POA) via email and in person informing her that the licensee will be initialing natural light therapy. This is intended as a holistic approach to help manage recent changes in resident mood and behavior and will be implemented in addition to any medication adjustments the family agrees to. CNS-B stated to have instructed staff on this new change. R2's Service Recap Summary dated December 2025, included documented service of care for personal possession assist from the dates from	01620		

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01620	Continued From page 11 December 1, 2025, to December 16, 2025. R2's Assessments dated October 7, 2025, and July 14, 2025, were provided. R2's most recent assessment was dated October 7, 2025, the assessment indicated it was for an annual assessment/90-day assessment. The licensee's RN did not complete a change of condition assessment on November 13, 2025, when the service of natural light therapy started for mood and behavior changes. On December 17, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated the natural light therapy was added to the care for personal possession assist and the RN did not complete a change of condition assessment. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2025, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 12 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 16, 2025, at 10:44 a.m., the surveyor reviewed a locked medication closet with unlicensed personnel (ULP)-F. The following expired supply of medications were observed and confirmed with ULP-F: -Smooth Lax, expiration date June 2021 -Halls triple soothing action cough drops, expiration date March 7, 2020 On December 16, 2025, at 11:02 a.m., registered nurse (RN)-C stated the medications came with R4, who was recently admitted and the as needed medications were simply missed. RN-C stated the licensee does weekly audit for expired medications typically and reorder medication as needed. The licensee's Medication Disposal policy dated	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25756	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INC	659 MULBERRY LANE MENDOTA HEIGHTS, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 13 August 1, 2022, indicated expired medications managed by the licensee will be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HEART TO HOME INC
659 Mulberry Lane
Mendota Heights, MN 55118
Dakota County
Parcel:

Phone:

License Info

License: HFID 25756

Risk:
License:
Expires on:
CFPM: Angelene Burnette
CFPM #: 5044; Exp: 2/6/2028

Inspection Info

Report Number: F1031251217
Inspection Type: Full - Single
Date: 12/16/2025 Time: 10am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Nurse Evaluator on site: Jenn Panitzke

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Cutting boards are utilized as food contact surfaces and not counters or plates.

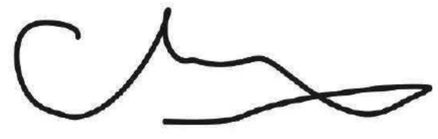
- Establishment is checking dish washer utensil temperature weekly (160F required).

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When cooking/preparing food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031251217 from 12/16/2025



Josh Cesaro-Moxley
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

HEART TO HOME INC
Mendota Heights
County/Group: Dakota County

Inspection Info

Report Number: F1031251217
Inspection Type: Full
Date: 12/16/2025
Time: 10am

Food Temperature: Product/Item/Unit: Yogurt**; Temperature Process:** Cold-Holding
Location: Refrigerator (kitchen) at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Ambient**; Temperature Process:** Ambient Air
Location: Refrigerator (lower level) at 30 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

HEART TO HOME INC
Mendota Heights
County/Group: Dakota County

Inspection Info

Report Number: F1031251217
Inspection Type: Full
Date: 12/16/2025
Time: 10am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No